

Writers' Guild-Industry Health Fund

Terence L. Young, Administrator

Dear Participant:

Your benefit plan states that the Fund may exercise the right of reimbursement. This means that when you collect for expenses under the plan and then you collect again for the same expenses from certain other sources, you become responsible for refunding payments made on your behalf.

You have made claims for which the accident appears to be one where our right or reimbursement may be applicable. Please complete and return the attached fact sheet and reimbursement agreement.

Sincerely,

Claims Department



1015 N. Hollywood Way • Burbank, CA 91505-2547
818.846.1015 • 800.227.7863 • FAX 818.566.8445 • 566.4416

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LIEN AND REIMBURSEMENT AGREEMENT

Out of any monies I receive in connection with an injury, illness, or condition that I sustained as a result of action or inaction by a third-party, and for which the Writers' Guild-Industry Health Fund (Fund) pays benefits or causes payment on my behalf, I shall reimburse the Fund and I give to the Fund a lien on my recovery, up to, but not in excess of the monies I receive. If the injury, illness, or condition was sustained by my dependent, I shall similarly reimburse the Fund and I give the Fund a lien, and by signing this agreement, my non-minor dependent shall reimburse the Fund and gives the Fund a lien.

The date the injury, illness, or condition to which this agreement applies was on or about .

The person or organization I believe responsible was

_____,
whose address is _____, and
whose telephone number is _____.

Signature of ill or injured person, or if a minor, signature of parent or guardian

Signature of Fund participant, if different

Print Name

Print Name

Dated:

Fund participant's Social Security Number

If a lawyer is handling this case for my dependent, or me I list below the lawyer's name, address and telephone number, and the lawyer signed this agreement to acknowledge the Fund's lien:

Lawyer's signature

Lawyer's street address

Print Lawyer's name

City, State, and Zip Code

Date

Lawyer's telephone number



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FACT SHEET

Employer: _____ Policy No.: _____

Name of Employee: _____ Soc. Sec. No. _____

Address of Employee: _____

- If a minor, name of legal guardian: _____

- Address, if other than employee: _____

Your policy contains a "Right of Reimbursement" provision and therefore you are requested to provide the following information in connection with the Sickness or Injury commencing on or about

1. Describe the circumstances involving the Sickness or Injury (include date, time and place):

2. Indicate the name, address and phone number of your attorney or insurance company.

3. Indicate the names, addresses and phone numbers of any other persons or organizations that you believe are the cause of your Injury or Sickness and explain why:

5. If these other persons or organizations have liability insurance, indicate the names, addresses and phone numbers of insurance carriers and policy numbers, if available:



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5. Indicate the names, addresses and phone numbers of these other persons' or organizations' attorneys:

6. Include any other pertinent information in regard to the Injury or Sickness: A copy of the insurance and/or police report filed is required.

I certify that the above information is true and complete to the best of my knowledge. I understand that providing false information may lead to refusal of my claim.

Employee's Signature

Date

PLEASE RETURN COMPLETED FORM TO:

WRITERS' GUILD-INDUSTRY HEALTH FUND
1015 N. HOLLYWOOD WAY BURBANK, CA
91505



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